

LIBERATING HUMAN POTENTIAL

A PARADIGM SHIFT IN HUMANITARIAN DEVELOPMENT



WHO

➤ **Real Medicine Foundation (RMF) is a US-based, nonprofit public charity headquartered in Los Angeles, with branches in the UK and Germany, and with offices and partners all over the world.**

Providing humanitarian support and development to people living in disaster and poverty-stricken areas, RMF has worked in 25 countries, with extensive ground operations in currently 19 countries, and has aligned with governments and international agencies, including the UN, to reach those most in need. RMF is in Special Consultative Status with the United Nations Economic and Social Council and in PVO Status with USAID, and is Implementing Partner with UNHCR in Uganda, with UNICEF in Pakistan, and with UNICEF, WFP and UNDP in South Sudan.

25

COUNTRIES

LOCAL SOLUTIONS



70+

ACTIVE INITIATIVES

WHOLE HEALTH



17+

MILLION TARGET POPULATION

SELF-SUFFICIENCY



THE CURRENT DEVELOPMENT LANDSCAPE

Building capacity in developing countries and eventually, self-sustainability without dependency – has that really been the purpose of humanitarian work on a large scale? Or is it actually much more self-serving, keeping a lot of people in their jobs and in business? Fact is that the wealth ratio between the richest and poorest countries keeps growing. In 1973 the gap was 44:1. In 2016, it had widened to nearly 80:1. Inequality has reached such extremes that now the richest 26 people in the world have the same amount of wealth as the poorest 3.8 billion.

Despite billions of dollars of investment in aid, global poverty is getting worse, now at more than 3.8 billion people. As of 2016, around 500 million more people had been added to the ranks of the extremely poor since 1981. Oxfam's report from January 2019 outlines how the wealth of the poorest half of the world's population has fallen by 11 percent, while the wealth of billionaires has increased by more than \$900 billion in the last year alone. The bottom 99.9 percent are not able to use their numbers to address the problems created because the rich have unequal access to those in power.

The World Bank and Sustainable Development Goals use a poverty line of \$1.90/day. But in many countries, this is not adequate for human existence, let alone for human dignity. In India, children living just above this line still have a 60% chance of being malnourished. 100 million children are estimated to be underweight in developing countries, which has serious consequences for their growth and development. 830 women die every day from preventable causes related to pregnancy and childbirth – 99% of these deaths occur in developing

countries. If people are to achieve normal life expectancy, the current poverty line has to be tripled, a minimum of \$5.70/day.

International development is failing because it fundamentally misses the point about poverty. It assumes that poverty is a natural phenomenon, a problem that exists out there. This view lends itself to technocratic interventions led by 'experts' in development 'science'. On a more popular level this approach manifests as quick-fix fads like merry-go-round water pumps, deworming campaigns, microfinance and laptops for children – projects that avoid thinking about the political context of impoverishment. It allows people to feel they are fixing the problem of poverty without ever having to confront power, or challenge the tenets of the prevailing economic order.

The present crisis presents a monumental opportunity to allow development as we know it to wither away and leave space for the evolution of a new approach: an approach framed not in terms of charity but in terms of justice, and focused not on symptoms but on systems. And in the frame of this systems change, values have to be reevaluated. Are we really treating each other as a global human family, with respect, dignity and compassion for each other? Are we allowing each other equal access to the resources on this planet, acknowledging that every single human being is valuable and deserves to live a life of dignity?

RMF firmly believes with Nelson Mandela, "It always seems impossible until it is done". In this spirit: We believe that a paradigm shift is possible in our lifetimes. And we will not rest until it is achieved.

WHY

➤ Liberating Human Potential.

RMF's WHY is "Liberating Human Potential", encouraging leadership and ownership in our teams and the people and communities we are supporting, building capacity and long-term self-sustainability for eventual independence.

Based on this WHY, RMF has developed a **Community-Based Sustainability Model**. We initiate programs by engaging with communities to assess existing resources. Rather than dictate what we can bring to the table for them, we allow communities to take the lead, and use what they already have committed to, prioritized, and hold as their primary goals. We assess the existing infrastructure, staffing, commodities, and facilities, and fill gaps and build capacity based on them rather than entering with a preconceived plan. We refer to this as **Community-Participatory Design** or, **Co-Design**. We accomplish this by:

- a. Identifying local leaders and team members – RMF only hires nationals for in-country operations – and then supporting/nurturing them into larger roles over time, **Liberating Human Potential**.
- b. We plan for longevity from the beginning. Every project is designed in phases with expansion, completion, or hand-off to local organizations/ government planned from the start after a needs assessment is completed.
- c. Since RMF's core values of respect and dignity are the basis of our work and are implemented globally, and since we always work in collaboration with the MOH/other ministries/government/other permanent stakeholders, we work 'serving their vision for their country', thus creating trust and buy-in, and eventually building capacity and independence since our ultimate goal is to have governments take over our models (accomplished with several projects already in several countries).

The Old, Donor-Reliant Model is the cornerstone of traditional aid programs and assumes that programs have a defined beginning and end. This means that a scope of work and project length is predetermined and upon completion, further funding is required or operations cease. Although this is the most common model currently used globally, there are very few instances where it is ideal. When programs are designed and implemented this way, they typically reach a project completion date and then efforts are made to obtain more funding to continue as the population is still in need. There are often gaps in services, or a complete end in services the community had come to rely on. Further, donors will typically require ongoing assurance that their investment is being well managed so reporting often becomes central to the program rather than the work itself. 40+ years of failed humanitarian development has used this model. Examples range from vaccination programs where full immunity requires a series of multiple injections but initial funding was allotted only for round 1, to large-scale failures where hospital facilities, water utility infrastructures, or schools were built with existing funding but no forethought went into how to secure a permanent workforce to staff them or maintain operating costs.

HOW

► Values: Respect and Dignity.

RMF's global work is based on the Core Values of Respect and Dignity.

RMF Teams: RMF's team members are chosen based on their alignment with these core values so they can be actively integrated and implemented in our work around the world. RMF has also developed programs to operationalize how to teach these values. Our Respectful Healthcare Training, for instance, is based on literature reviews and research from the fields of medicine, nursing, social sciences, philosophy, and religion. Concept analyses on respect, dignity and compassion were done, behavioral assessment research was evaluated, and a program to operationalize how to teach these values was designed. The concepts encompassed in the training program are not only intentionally taught, but also measured as concrete outcomes.

All of RMF's teams around the world are pre-identified and selected initially based on their training and experience but the final selection is based on '**Attitude and Work Ethics**'. We look for individuals in Stage 5, Self-Actualization, of 'Maslow's Pyramid', realizing personal potential, self-fulfillment, seeking personal growth and wanting to contribute to something bigger than themselves. Our experience is that the strongest possible teams are created if we make these criteria a priority. Investing in the right persons to nurture into leadership roles makes

for a unique workforce, one that is both loyal and independent. In addition, these selection criteria create strong ownership by our teams, which in turn inspire them to come up with on-the-ground solutions, based on the actual needs and potential in the communities. Some of our best programs have been suggested by our local teams. RMF's team members '**live the experience**'; they are indigenous, understand the hardships of recipients' first-hand, and are therefore passionate and committed in their roles. In this way, we empower local leadership at every level within our work.

RMF pays very fair wages and always works with staff to expand their scope and skill set so they can increasingly take on more leadership responsibilities. We provide travel for education and conferences when there is added value. We treat staff fairly, respectfully, and build every relationship in the organization on trust. This way, we are able to extend a circle of respect, dignity, and trust since our teams around the world share the same values, and work together with great motivation, seamlessly, joyfully, and efficiently. They in turn choose new team members based on these values, and perpetuate a structure of leading by example. It is RMF's belief that every person has a different part in our global community. Regardless of rank, role, or training,

***Old Model:** is to keep a full staff at all times, thereby reinforcing the respective organization's seemingly overwhelming global presence. This has become such a norm that a lot of donors consider it evidence of credibility and experience. Maintaining this image means organizations must spend money on large offices with full staffing and a big percentage of their budget on generating press releases, social media and other forms of 'smoke and mirrors' to give the perception that they are omnipresent. The field staff (especially key staff) is typically foreign, and often requires a significant amount of transportation, housing, evacuation insurance, stipends, and other benefits in addition to ex pat salaries in order to be enticed to take some of the posts. On top of that, they typically hold the position temporarily with many using certain postings (in 'undesirable' locations) to work their way up the internal ladder to higher paying management positions at organization headquarters or in more desirable locales. This results in communication, operations, and relationship-building being often inconsistent, frequently disruptive as position changes may take place mid-program, riddles with language and cultural barriers, and often involve working with key personnel that are not emotionally committed. It also means that working with local government agencies is deeply hindered and very often entirely omitted from program designs.*

each person is valued and crucial to the greater picture. We coined the notion of ‘**Friends Helping Friends Helping Friends**’, treating each other and the communities we are serving with the respect and dignity you would give to friends.

Quality of Care

Another way that RMF promotes respect is by making sure all healthcare staff are following the tenets of evidence-based practice. That means that the quality of healthcare someone receives in the US, India, or Uganda should all be the same best practices modern medicine. It also means maintaining the same high standards of privacy that, for instance, HIPAA laws protect Americans with, when we implement in Africa or Asia. *Many traditional organizations cut these corners to save money and time in implementation, thereby also reducing accountability.*

Real Medicine: Medical/Physical, Emotional, Economic and Social Support

For RMF, another cornerstone of respect and dignity is viewing, and ultimately, healing, people, communities, and nations holistically. Instead of specializing in narrow areas and then presenting to a community to parlay our expertise, we allow communities to voice their own needs, priorities, and desires, and then serve as facilitators to help them meet these needs and allow them to thrive as persons and communities. We believe that ‘real’ medicine is focused on the person as a whole by providing medical/physical, emotional, economic and social support. This means that while our work often starts out and is based in the health sector, we use this platform for education, school support, vocational training,

water, sanitation, or gender equality as a healing modality. In this way, we address the full spectrum of health, healing and community resilience, **Igniting the Potential** of the people we are supporting, and allowing them to be strong and self-sufficient – which is widely recognized as a **Paradigm Shift** in humanitarian aid and development.

Program Design and Implementation

RMF’s **collaborative design process** takes an entirely new and different approach to program design and implementation; rather than deciding what communities need and then working to convince them to become engaged, we let communities self-identify their own needs and then serve as their facilitators to progress. This model is more efficient in terms of cost but certainly creates the need for more partnership and less power retention, which is why many agencies are resistant to this model. Our program design involves team members working collaboratively with communities, local leaders, and government once needs/issues/gaps have been identified. We take local solutions seriously and base our programs on collaborative solutions, thus creating buy-in and local and community ownership. Some of our best and largest projects were initiated based on suggestions from team members on the ground; many have gained global accolades.

RMF’s model centers around ethnographic methodologies, the immediate creation of working groups for each program which provide ongoing feedback to our teams so rapid iteration can be done and program design

***Old Model:** Most agencies within the humanitarian aid and development space acknowledge that respect, dignity and compassion are important values. However, traditional agencies do not develop and implement programs and interventions with these values as foundations, benchmarks, or measured outcomes. Typically, dignity is considered a preferential side effect of their work.*

improved day-by-day. This means that certain benchmarks and outcome measures can not be guaranteed to donors on the front end as the program model will go through several evolutions of change and improvement based on the community and participant needs and desires. This results in interventions that embrace a deeper and more comprehensive inclusion of cultural, economic, and social components, guaranteeing more effectiveness. This is doubly beneficial since large investments in programs before implementation begins (such as most traditional models) often yield programs that people do not want or need, or worse, contain cultural or social misunderstandings that upset community members rendering an entire program unsuccessful.

RMF’s model also includes **collective intelligence**, which means working together with a variety of partners that are similarly engaged in the community. We believe that bringing together the experts in all pertinent fields improves programs and is worth the effort and time that coordination often takes even if we might be considered competitors in other arenas (such as when seeking external funding sources). Rather than guard our ideas, we seek to share them and

build upon them with others, thus maximizing our outputs. Too often in humanitarian development, services are replicated in some areas while absent in others due to lack of coordination by agencies working in similar niches without talking to each other.

On our platform of collaborative design and collective intelligence, a **continuous improvement process** is initiated. This often presents as working groups of team members, local government, and community members presenting ideas, giving feedback, and using this information to redesign, tweak, adapt, and adjust programs during implementation rather than remaining stagnant until the end date. Thus we often end up with unexpected extra outcomes, ethnographic, cultural, and environmental dimensions of programs that might otherwise never be identified. All of this becomes readily available to stakeholders rather than guarded and proprietary; both our successes and failures are discussed, as a means to add value to the global development professional platform to improve the lives of everyone.

Old Model: Many development and humanitarian aid agencies follow a **unilateral external program design**, developing their programs based on desk research, funding requirements, and existing staff expertise/areas of interest. Next, local contacts are explored to find the ideal implementation site. The program is then initiated and monitored for the duration of the predetermined amount of time allotted and final reporting is submitted to donors/ stakeholders. A significant amount of resources often ends up being spent on 'end-user adoption' or more simply put-how to get the target population or program participants to actually utilize the services being provided. Additional funding is often then sought in order to continue or expand programs and modify implementation for the next portion of the project timeline. Outcome measures are predetermined based on hypotheses and programs are problem-oriented, that is, based on the elimination of identified malfunctions in an existing system. We call this system a **terminal design model** because it is finite, and thereby very limiting. Many of these models are proprietary and many agencies using this model lean towards working with the same group of partners on various projects globally both as a means to protect their intellectual property, and as a way to avoid revealing any systems failures externally. The reason this model does not work well is that it builds resistance, rather than support and partnership, from host communities. There are often large omissions in addressing the unique environmental, economic, cultural, or religious details of a specific locale that often can make the difference between a great program and a complete failure. Additionally, there is a much larger and more cumbersome (and costly) learning curve to accomplish localization because it is typically done with a lack of close coordination with government bodies and community representatives.

WHAT

Real Medicine Foundation (RMF) provides humanitarian support and development to people living in disaster and poverty-stricken areas, focusing on the person as a whole by providing medical/physical, emotional, economic, and social support. RMF's vision is to move beyond traditional humanitarian aid programs by creating long-term solutions to healthcare and poverty related issues, implementing sustainable models and leveraging existing resources through partnerships with local governments, health systems, and local staff. RMF has worked in 25 countries on 5 continents, with currently active programs in 19 countries, including disaster relief, health systems strengthening, maternal child health, psycho trauma support, economic/livelihood programs, and health education outreach using innovative approaches such as mHealth solutions and institutionalization of Respectful Maternity Care practices.

Based on today's best practice Modern Medicine, RMF utilizes a Comprehensive Integrative Health Care Model. Once survival and immediate health care needs are addressed, we establish mobile and stationary health clinics employing regional medical doctors, other healthcare professionals and supporting staff, and tailoring them to local needs. Using these clinics as hubs, we implement additional modules of care that address the priority needs of the region being served. Programs such as Maternal Child Healthcare, Malnutrition Eradication, HIV/AIDS Care, Malaria Treatment and Prevention, mHealth, and Vocational Training and Livelihood projects are introduced to build on

the existing infrastructure already in place. RMF has also developed and implemented strategies for access to secondary and tertiary care, support and upgrade of hospitals and training of medical personnel, to build health care capacity and to strengthen health systems on a larger scale.

We believe in the human ability to transform - that the people in developing and disaster stricken areas are most capable of creating solutions to their unique challenges. We employ, train and educate locals, enlisting cutting edge technology and modern best practices, thus producing innovative solutions and strong communities that sustain and grow (health care) capacity. We ignite the potential of the people we are supporting - turning aid into empowerment and victims into leaders.

What Makes RMF Different

We are often asked what makes RMF different from other organizations that also work in global development. To answer somewhat simply, many organizations have carved out a very tangible and narrow niche (such as clean water or famine relief, for example) and they can therefore succinctly do an 'elevator pitch' to potential donors. On first look, it may seem complicated that RMF delves into so many specialty areas: mHealth, hospital renovation, vocational training, emergency relief, and more. However, RMF is more focused on processes, models, and the development of a solid structure on which programs addressing any specialty area can be built.



This is why we describe our work as an integrated comprehensive model, taking a holistic approach with community resilience and independence as the end goal.

While clearly more broad as outcome measures (than say, being able to report on numbers of vaccines delivered in a given population), we feel that these goals dictate us developing programs that are not only more sustainable, but also implicitly give ownership over to the recipients

with RMF facilitators assisting them in a path to self-reliance and self-determination. That is not to say we don't also measure outcomes quantitatively (after all, we also distribute supplies and vaccines) but they are not the entire premise of our work. These components of our models are merely the result of building a paradigm-shifting system of accountability, resilience, and partnership so that communities can ultimately address their own needs.

Example for RMF's Model

KIRYANDONGO REFUGEE SETTLEMENT, UGANDA

Kiryandongo Refugee Settlement in Bweyale, Uganda is a UNHCR managed refugee settlement that provides shelter, land and support for now more than 100,000, comprised of Ugandan IDPs and refugees from South/Sudan, Kenya, Congo, Rwanda, and Burundi. Refugees are some of the world's most vulnerable populations and are usually in need of a myriad of services. RMF has been partnered with UNHCR and the Ugandan Office of the Prime Minister (OPM) in supporting Kiryandongo and the greater surrounding community of Bweyale (30,000 residents) with health care, education and vocational training since 2008.

RMF has consistently supplied the 100-bed Panyadoli Health Center III, located in the middle of the Kiryandongo Refugee Settlement, with medicine, medical supplies and operational support. In collaboration with UNHCR and the OPM, RMF, on an as-needed basis, periodically repaints, provides mosquito nets, beds and mattresses, and keeps critical medical inventories supplied and in stock. RMF cleaning staff regularly cleans the patient wards and grounds of the health center compound to ensure hygiene and low mosquito and other infestations near the buildings. RMF has also installed and maintained solar powered water pumps, pipes, and taps that supply all the health center buildings.

In July 2014, RMF signed a tripartite agreement with UNHCR and the Government of Uganda, becoming official UNHCR Implementing Partner for Health Programs, and starting a significant expansion of our healthcare services at Kiryandongo through the three established health centers at Kiryandongo Refugee Settlement, namely Panyadoli Health Centre III, Panyadoli Hills Health Centre II, and the Reception Centre Clinic, as well as through large community outreach programs that include a fourth health center, Nyakadot Health Centre II; one more health center, Nakivale, was added in 2015. Beneficiaries of the healthcare services are also Uganda nationals; the host community comprises more than 74,000 people.

When the Kenyan refugees arrived at the Kiryandongo Refugee Settlement in 2008, there was very little support in terms of school fees for their children, and there was no provision for a nursery school at the settlement. Following the request of the community, RMF stepped forward to establish a school support program to cover fees and supplies for Nursery, Primary and Secondary School children of the Kenyan refugee community at Kiryandongo. In the subsequent years, students from South/Sudan, Congo, Burundi and Rwanda have been accepted into our program as well. RMF paid a portion of the tuition fees, school uniforms, school supplies, and examination fees for the students of parents unable to afford



Kiryandongo Refugee Settlement, Uganda

the fees and often the full fees for unaccompanied refugee children. We also provided funding for the annual registration of candidates in Senior Level Four and Senior Level Six that are in our sponsorship program, and facilitated candidates taking their national exams in the city of Masindi, covering the cost and travel expenses for the final examination tests. In close communication with the students' caregivers, we request those caregivers who can afford it to take on bigger portions of the required school fees so we can take on new students in the program.

In April 2011, after being presented by the refugee community with issues surrounding the lack of skills and vocational training for students graduating from the settlement high school, and for many refugees having had to abandon their training and businesses in their home countries, RMF initiated a Vocational Training Program (Panyadoli Vocational Training Institute, PVTI) at the Kiryandongo Refugee Settlement. After researching which skills and programs might provide the quickest income-earning opportunities and the most economic investment requirements for RMF and with the feedback from the community, we decided on: Hairdressing/Beauty Therapy and Tailoring training. We renovated a disused building in the settlement, purchased tailoring and hairdressing supplies, and funded the salaries of vocational tutors. This program is part of the economic component of RMF's overall humanitarian vision, the 'focus on the person as a whole'.

The longer-term vision for this vocational training center is to be one of several models for income generating opportunities for the populations we are supporting around the world so they eventually can be self-sufficient again.

The Vocational Training Center is continuing to generate some income for the program by tailoring garments, i.e. uniforms for the nurses at RMF's Panyadoli Health Center III, and by offering hairdressing services to the refugee population at Kiryandongo and its surrounding communities. RMF's support in running the Vocational Training Institute has helped empower Panyadoli youth with livelihood skills, promoting self-reliance among the youth community. A number of individuals who have completed training at PVTI now own shops in different trading centers and others are employed in shops in the region.

Building on RMF's established structure for vocational training, we added new partnerships, i.e. with JICA (Japan International Cooperation Agency) and Windle Trust, adding new programs – Carpentry and Joinery, Bricklaying and Concrete Practice – and new students.

In 2013, RMF added a Tailoring Shop Program to set up sustainable, market-based business opportunities for the refugee and IDP graduates of our Panyadoli Vocational Training Institute (PVTI) Tailoring Program.

We started this program with the sponsorship of 10 RMF Tailoring Training graduates to set up their own Tailoring Shop businesses. RMF purchased sewing machines, enough fabric for several months, threads, needles, and enough tables and chairs to set up new shop locations for each of the 10 selected. RMF also paid the monthly shop space rent for one year to help the tailors become profitable and save enough money to continue their businesses in a sustainable fashion without further donations. After a 3-month grace period, the tailors were also expected to give 10% of their profits back to PVTI; these funds were to be used to procure supplies for the next round of vocational training students.

In response to requests by the members of our Tailoring Shop Business Program, a training was conducted for the sponsored tailors, covering business management, business planning, marketing management, record keeping, customer care, and creativity in business by one of RMF's vocational instructors, a businessman in his home country, DR Congo.

The ten tailors sponsored by RMF are doing very well; several of them are very successful with flourishing businesses. RMF is looking to extend this program to other disciplines.

In December 2015, we interconnected two sections of our vocational training by providing funding for our Bricklaying and Concrete Practice graduates to construct a much-needed new building for the hairdressing/beauty therapy program, providing an additional training space for the hairdressing/beauty therapy department, and also showcasing the skills of the bricklaying and concrete practice graduates. PVTI graduates have also been hired for RMF's hospital building projects in Kiryandongo and Bidibidi, Uganda.

Through more than a decade of RMF implementation in Kiryandongo, the settlement has become a point of reference for the whole region and RMF's model a success story to be replicated.



Kiryandongo Refugee Settlement, Uganda